

THE COMMISSION ON ORGANIZATION OF THE
EXECUTIVE BRANCH OF THE GOVERNMENT

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medical activities



A Report to the Congress

MARCH 1949



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U.S. Commission on Organization of the
Executive Branch of the Government.
Committee on Federal Medical Services

Reorganization of Federal Medical Activities

*A report to the Congress by the Commission on
Organization of the Executive Branch of
the Government, March 1949*

The Commission on Organization of The
Executive Branch of the Government

HERBERT HOOVER, *Chairman*

DEAN ACHESON, *Vice Chairman*

ARTHUR S. FLEMMING

JAMES FORRESTAL

GEORGE H. MEAD

GEORGE D. AIKEN

JOSEPH P. KENNEDY

JOHN L. McCLELLAN

JAMES K. POLLOCK

CLARENCE J. BROWN

CARTER MANASCO

JAMES H. ROWE, JR.

Letter of Transmittal

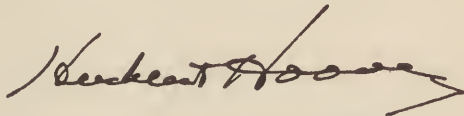
WASHINGTON, D. C.,
16 March 1949.

DEAR SIRs: In accordance with Public Law 162, Eightieth Congress, approved July 7, 1947, the Commission on Organization of the Executive Branch of the Government submits herewith its report on Medical Activities, and, separately, as Appendix O, the task force report on Organization of Federal Medical Services, and a supplemental task force report on an independent medical agency.

The Commission wishes to express its appreciation for the work of its task force and for the cooperation of officials of departments and agencies concerned with this report.

Commissioner James Forrestal, in view of his position as Secretary of Defense, abstained from the consideration and preparation of this report, and he reserves judgment on its subject matter until such time as studies, initiated by him in the National Military Establishment, are completed and available for his consideration.

Respectfully,



Chairman.

The Honorable

The President of the Senate

The Honorable

The Speaker of the House of Representatives

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I. Reorganization of Federal Medical Activities¹

The immediate purpose of the Commission, in recommending reorganization of Federal medical activities, is to unite the functions now in five major agencies so as to eliminate overlap, waste, and inefficiency. The proposed form of organization is a unification in which each of the major agencies will have an advisory voice in management.

However, the much wider and critically necessary objectives are:

First: To provide better medical care for the beneficiaries of the Federal Government's medical programs.

Second: To create a better foundation for training and medical service in the Federal agencies.

Third: To reduce the drain of doctors away from private practice. The country is now dreadfully short of doctors.

Fourth: To provide better organization for medical research.

Fifth: To promote a better state of medical preparedness for war.

¹ **RESERVATION:** Commissioner James Forrestal, in view of his position as Secretary of Defense, abstained from the consideration and preparation of this report, and he reserves judgment on its subject matter until such time as studies, initiated by him in the National Military Establishment, are completed and available for his consideration.

Recommendation No. 1

To accomplish these purposes, the Commission recommends the establishment of a United Medical Administration into which would be consolidated most of the large-scale activities of the Federal Government in the fields of medical care, medical research, and public health (in which we include preventive medicine).²

It should be said at once that, under this plan, the military medical services would remain intact, except for hospitalization within the United States. Each of the three services would retain one major teaching and research center (such as the Naval Medical Center at Bethesda, Md., and the Walter Reed General Hospital, Washington, D. C.). The professional personnel of the services may be assigned to the new Administration for duty, research, and training. The proposed United Medical Administration would provide the major part of all hospital care required by the military forces in the continental United States.

The Veterans' Administration would continue to certify patients for treatment and would determine disability, ratings, etc., but the United Medical Administration would look after veterans' medical care.

The recommendation of our task force that medical supply be centralized in a single agency, preferably in one of the

² **DISSENT:** Vice Chairman Acheson, Commissioners Aiken and Rowe dissent from establishing a new agency in a statement given on p. 41.

² **DISSENT:** Commissioner Brown dissents from this recommendation in part, and Commissioner McClellan concurs in general with this dissent, in statements given on pp. 37 and 40.

Armed Forces or in the United Medical Administration, merits favorable consideration.

In reaching the conclusion that medical services should be unified, the Commission had the aid of extensive surveys by its distinguished task forces on Medical Services and on the National Security Organization. The recommendations set forth in our report are generally in accord with those submitted by these two task forces.

The task force on Medical Services was instructed to base its original report on the premise that "the Commission will recommend a Cabinet Department embracing health, education, and security." However, in view of the size of the medical operations of the Federal Government and the extreme dissimilarities among the activities which would have composed such a department, the task force was later requested to consider the advisability of placing medical service functions in a single agency. Its supplementary report favors very strongly a separate United Medical Administration. This supplement, with the task force's main report (Appendix O) is being transmitted separately, along with this Commission report.

Medical Obligations of Government

The Federal Government is attempting to give varying degrees of direct medical care to 24,000,000 beneficiaries—about one-sixth of the Nation. Veterans estimated to number over 18,500,000 constitute the bulk of this large segment of our

population. Present and future personnel of the Military Establishment will increase this number as they become eligible for veterans' benefits upon discharge from service.

At one extreme of those receiving medical care are members of the armed forces, their dependents, merchant seamen, and other lesser groups totaling upwards of 3,000,000 persons. They are eligible for almost complete medical care.³ At the other extreme are about 2,000,000 employees of the Federal Government. They are eligible for medical care only for industrial accidents and outpatient service of the industrial hygiene type.

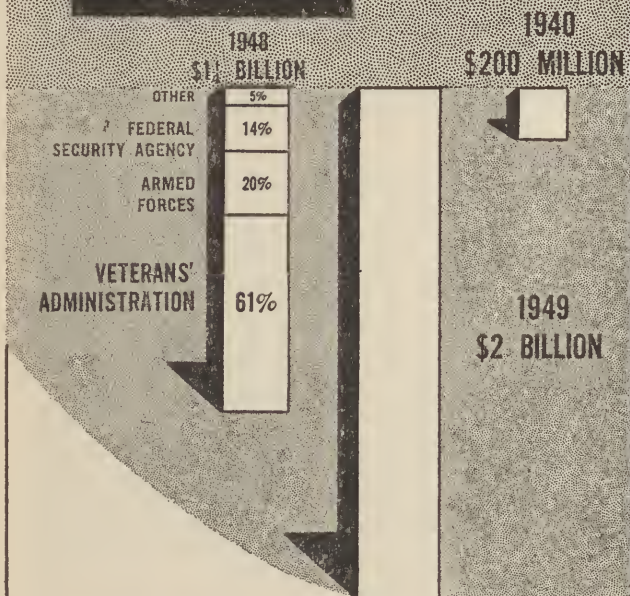
Over 40 Government agencies render Federal medical service. In this fiscal year they plan to spend nearly \$2 billion, about 10 times the amount spent in 1940. Last fiscal year's expenditures were about one and a quarter billion dollars. Most of this money (61 percent) was spent by the Veterans' Administration. The armed forces expended more than half of the remainder and the balance represented costs in the Federal Security Agency, the Department of Agriculture, the Atomic Energy Commission, the Department of the Interior, the Department of Justice, and many other agencies. (See chart.)

Over 85 percent of the total expenditures during the last fiscal year was for direct medical care. The rest went for public health, research activities, training, and administration. Expenditures for research were less than 4 percent of the total.

³ Dependents of members of the armed forces receive full medical care only under certain circumstances.

FEDERAL MEDICAL EXPENDITURES

SERVICE and BUILDING



PROPOSED HOSPITAL CONSTRUCTION TOTAL: \$1½ BILLION

HILL-BURTON PROGRAM

VARIOUS AGENCIES

VETERANS' ADMINISTRATION

\$225 MILLION

\$200 MILLION

\$820 MILLION

Almost one-half of the estimated cost of the Veterans' Administration medical program for this fiscal year will be for construction of hospitals. Its hospital building program, until recently, contemplated a total expenditure of \$1.1 billion. Projects for the construction of new hospitals by other agencies total another \$200,000,000. At the same time, the Government is planning to spend \$225,000,000 over the next 3 years to aid non-Federal hospital construction under the Hill-Burton Act. Thus the plans for hospital construction totaled around \$1.5 billion.

However, after our task force's report was made public, the President altered the Veterans' Administration construction program by cancelling authorizations for 24 hospitals with an aggregate capacity of 11,000 beds, and reduced the size of 14 additional hospitals by an aggregate of about 5,000 beds. The Veterans' Administration estimates that this action will result in a saving of \$280,000,000 in construction costs alone, thus reducing its projected \$1.1 billion program by that amount. This will be done without reducing the quality and extent of medical service to the veterans.

II. Deficiencies in Present Conduct of Medical Activities

1. General

More than half of the departments and agencies of the Federal Government conduct medical or health activities. These agencies compete for doctors and other technical personnel, and for funds. There is no central supervision of their activities; and they operate under diverse policies with respect to quality of treatment, types of beneficiaries served, types of research, and areas of authority.

The enormous and expanding Federal medical activities are devoid of any central plan. Four large, and many smaller Government agencies, obtain funds and build hospitals with little knowledge of, and no regard for, the needs of the others. They compete with each other for scarce personnel. No one has responsibility for an over-all plan. There is not even a clear definition of the classes of beneficiaries for whom care is to be planned. The Government is moving into uncalculated obligations without an understanding of their ultimate costs, of the lack of professional manpower available to discharge them, or of the adverse effect upon the hospital system of the country.

It is fundamental that whatever care the Government provides must be of the highest quality. The health of the

Nation demands the maximum employment of present scientific knowledge to control disease, and of research to find new means for the prevention of disease. Such research must be stimulated and supported to the maximum limits of available manpower. The Nation's future can best be protected by using every means to prevent disease, rather than by providing unlimited hospitalization to treat it. Medical care offered by the Federal Government should be a model for the Nation.

The present methods being employed by the Federal Government make it impossible to achieve these objectives. It is essential that Federal medical services be so organized as to provide for over-all planning and for execution of these plans.

2. Dissimilarities in Construction Costs

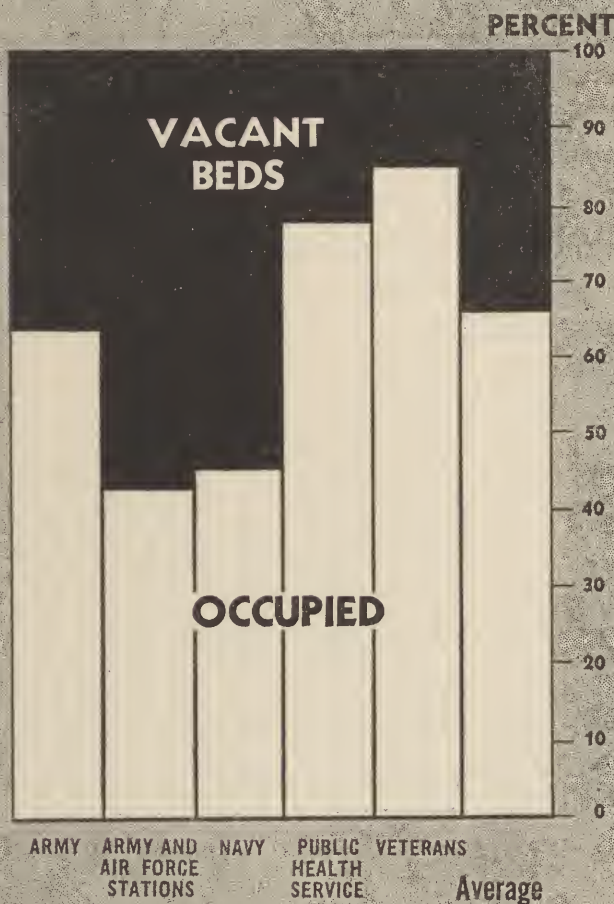
The per bed construction cost varies from \$20,000 in the larger hospitals to from \$30,000 to \$51,000 in the small ones. This compares with an estimated cost of \$16,000 per bed in voluntary hospitals.

3. Failure to Utilize Capacity

While these great new construction programs are going forward, there is a large unused capacity in existing Federal hospitals. On June 30, 1948, there were only 155,000 patients in Government hospitals having a capacity of 255,000. (See chart.) Yet, despite the President's recent action reducing its building program by 16,000 beds, the Veterans' Administra-

USE OF FEDERAL HOSPITALS

(GENERAL HOSPITALS, AS OF JUNE 30, 1948)



tion alone is planning or has already contracted for 38,000 additional beds, of which 15,000 are under contract. Continuation of present policies may lead to a hospital system in 1980 of 300,000 beds for the Veterans' Administration alone. The armed forces plan an additional 5,000.

4. Lack of Trained Manpower

There is insufficient medical manpower to staff existing facilities. In the Veterans' Administration, 5,600 beds are now closed because of inability to service them. The best opinion is that staff personnel is available for only about 120,000 Veterans' Administration beds. Construction is far outrunning available manpower.

None of the Federal agencies has the manpower resources in sight to meet its responsibilities. This shortage is particularly acute in the armed forces, where the lack of medical specialists is critical. The situation is neither temporary nor self-correcting. Federal agencies, as presently organized, compete with each other and civilian institutions, thereby aggravating conditions. They do not make proper utilization of their physician personnel. There is no planning by the Federal organizations in relation to the medical and hospital resources of the country as a whole.

5. A Medical Draft

This summer, the tour of duty of some 1,700 medical officers in our armed forces, trained under the wartime V-12 program and the Army Special Training Program (ASTP) will expire. Most of these young physicians have indicated their desire to enter private practice.

Great difficulty is being encountered by the armed forces in voluntary recruitment of medical personnel. It has been suggested that it will be necessary to draft certain medical personnel to replace the young physicians who are leaving the service. This is a policy matter for the Congress to determine.

Even if Congress should enact a draft law for medical personnel, it would still be improbable that the armed forces could obtain sufficient numbers of medical and surgical specialists. This is absolutely essential if the men in the armed forces are to get adequate medical care.

6. The Varied Quality of Service

The most important result of this situation is its effect on the quality of medical care which is available to the beneficiaries of this system. This is inadequate as far as military personnel are concerned.

7. Lack of Clear Policy on Beneficiaries

An enormous plant is being built for groups of beneficiaries, to many of whom the Federal Government has no clearly defined obligation. Veterans with nonservice-connected disabilities are receiving care in Veterans' Administration hospital beds, under an authorization to hospitalize them only if beds are "available." Yet about 100,000 Veterans' Administration hospital beds have been built or authorized which serve no purpose except to make beds available for nonservice-connected cases. It may be presumed that Congress must have expected that care to this extent would be given; otherwise it would not have made appropriations for the beds. But the fiction of limiting the right to such care only if a bed is "available" leads to the construction of a Federal hospital plant at staggering costs, although much of the hospitalization might be more economically provided in community hospitals on a reimbursable basis.

Because veterans with nonservice-connected disabilities are authorized to receive only hospital care, it has not been possible to give them outpatient care, nor effectively to employ the kind of preventive measures that might avert long, chronic hospitalization. The present eligibility provision for such cases is highly uncertain in operation, giving the veteran no assurance of hospital care when he needs it. The fact that hospital care can be obtained merely by signing a statement indicating inability to pay has the effect of giving care to some who are in much less financial need of this assistance than are others who do not apply for it.

Over 60 years ago an appropriation act authorized medical officers to care for dependents of Army personnel "whenever practicable." On the basis of this act, some 900,000 dependents of Army and Air Force personnel are receiving, or are considered eligible for, substantially free medical care. Congress has supported this practice by appropriations year after year.

8. Failure To Make Best Use of Highly Skilled Private and University Physicians

There are not enough highly skilled specialists in the Federal service. In an effort to remedy this situation, the Veterans' Administration established in 1946 a program for utilizing the best skilled physicians and surgeons in the Nation, both in private practice and in universities. (Other agencies have not followed this lead as effectively or extensively.) The hospitals so staffed would become part of a United Medical Administration which would thereby be in position to give a far better caliber medical care to all services. This not only would benefit those receiving care, but it also would be invaluable in improving the training opportunities for medical personnel within the Federal Government.

For the physicians and other skilled medical personnel in the armed forces, this would offer a great opportunity. It would be possible, for instance, for the Surgeons General and the Air Surgeon to detail military personnel to hospitals having superior facilities, a more varied clinical load, and more expert instruction.

III. The Proposed United Medical Administration

Only the creation of a new United Medical Administration can remedy the weaknesses of the present organization and give the leadership, direction and planning urgently needed. To it would be transferred the Government's major services in the field of medical care, public health, and medical research.

The Nation's vast medical services, which we have noted lack any central plan of operation, require unified responsibility. The Government must have a central plan if waste and inefficiency are to be avoided. The advantages of unification of Federal medical services include the following:

- a.* The general standard of Federal medical care would be improved.
- b.* There would be central supervision of the major Federal medical care, public health, and medical research activities. Unified responsibility is the key to good management. The President, the Congress, and the public could look to one man for results.
- c.* Construction costs could be standardized and reduced.
- d.* Federal hospitals could be utilized to the fullest extent by eliminating present distinctions as to the particular types of beneficiaries for which each can care. After all, a patient

is a patient whether he is a veteran, a merchant seaman, or in the Army, Navy, or Air Force.

e. The medical manpower at the call of the Federal Government could be used to the fullest extent, and present deficits in skilled personnel could be greatly reduced.

f. The need for any draft of medical manpower in time of peace would be greatly lessened.

g. The cost of health and medical services would be clearly identified and known to Congress.

h. The facilities of private hospitals and the skills of physicians in private life and in the universities could be utilized far more effectively than they are now.

Organization

This unification does not contemplate the creation of an additional Government agency in the usual sense. It proposes uniting the facilities and resources of existing agencies.

The Administration should be headed by an outstanding Administrator. He should report directly to the President. He should be the ablest medical and health administrator whose services can be obtained by the Government. The Administration should be manned by career personnel drawn initially from the various agencies whose functions are recommended for transfer to the new United Medical Administration, supplemented by medical officers whom the armed

services would have the right to detail for training and rotation.

This practice of detailing medical officers from the armed services would offer marked advantages. It would make possible far better training for these medical officers and they would be given more interesting, and broader, opportunities in the field of medicine. The result would be far better care for the military personnel for whose health they are responsible.

In addition, the Administration should utilize to the full medical personnel of proved competence in private practice and in the universities.

Advisory Board

Recommendation No. 2

Therefore, the Commission recommends that the Administrator of the United Medical Administration should be assisted by an advisory board, consisting of the Surgeons General of the Army and Navy, the Air Surgeon, and the Administrator of Veterans' Affairs or his representative.⁴ This board should advise the Administrator on policies. Thus, we propose a unity of services in the national interest, rather than separate services to special groups.

⁴ **DISSENT:** Chairman Herbert Hoover and Commissioner Carter Manasco dissent from limiting the Board's authority to advising the Administrator. The dissent in detail is given on p. 33.

Over-All Management

In our first report, we recommended that all departments and agencies should have adequate direction at the highest level. In the case of the United Medical Administration, there should be three Assistant Administrators who might be either professional men or general executives of wide experience.

Particularly in the hospitalization field, the function of management research should be emphasized. Furthermore, arrangements should be made for adequate liaison with Congress. One of the Assistant Administrators should be assigned to the supervision of the following officials:

- a.* GENERAL COUNSEL.
- b.* FINANCIAL OFFICER (budgeting and accounting).
- c.* SUPPLY OFFICER.
- d.* MANAGEMENT RESEARCH OFFICER.
- e.* PUBLICATIONS AND INFORMATION OFFICER.
- f.* DIRECTOR OF PERSONNEL.

Recommendation No. 3

We recommend that the Administrator and three Assistant Administrators be appointed by the President with the advice and consent of the Senate. All other officials in the Administration should be appointed by the Administrator and due consideration should be given to the promotion of properly qualified personnel in the career service.

PROPOSED

ORGANIZATION

OF THE

UNITED MEDICAL ADMINISTRATION

THE
PRESIDENT

ADMINISTRATOR
—
TWO ASSISTANT
ADMINISTRATORS

Assistant
Administrator
in Charge of
Staff Services*

ADVISORY BOARD

- SURGEON GENERAL
OF THE ARMY
- SURGEON GENERAL
OF THE NAVY
- AIR SURGEON
- ADMINISTRATOR OF
VETERANS' AFFAIRS

HOSPITALS

PUBLIC
HEALTH

RESEARCH

- *Staff Services
- General Counsel
 - Finance
 - Supply
 - Management Research
 - Publications and
Information
 - Personnel
 - Congressional Liaison

Components of Medical Administration

Recommendation No. 4

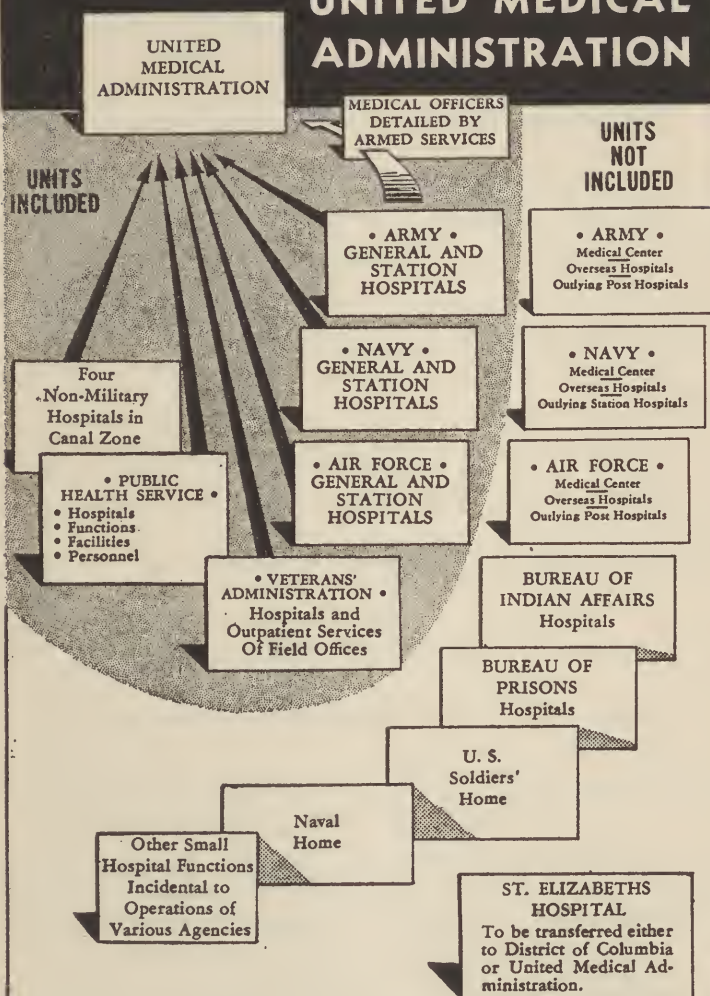
We recommend that the functions, facilities, and the personnel for medical care of the following activities should be transferred to the United Medical Administration.

- a.* The general hospitals of the armed forces in the continental United States (except a medical center for each of the three services), and station hospitals (certain of which the Navy calls "dispensaries") in the continental United States except those at outlying posts so located that other hospitals of the United Medical Administration would not be near enough to provide the care required.
- b.* The hospital functions of the Veterans' Administration in toto, including the outpatient services in the field offices of the Veterans' Administration.
- c.* The four nonmilitary hospitals in the Canal Zone.
- d.* The hospitals of the Public Health Service.
- e.* The functions, facilities, and personnel of the Public Health Service.

St. Elizabeths Hospital, now in the Federal Security Agency, should either be transferred to the District of Columbia or included in the new Administration.

FORMING

THE PROPOSED UNITED MEDICAL ADMINISTRATION



Hospital functions which should not be transferred include:

- a.* The armed forces station hospitals above excepted, together with all armed forces hospitals overseas.
- b.* The hospitals of the Bureau of Indian Affairs.
- c.* The hospitals of the Bureau of Prisons.
- d.* Other small hospital functions such as those which are incident to the operations of the Tennessee Valley Authority and the Atomic Energy Commission. The Indian and prison hospitals should, however, be assisted in procuring staff by professional personnel from the United Medical Administration.
- e.* The U. S. Soldiers Home in Washington and the U. S. Naval Home in Philadelphia.

Our task force states in substance as follows:

. . . 1. As to armed forces' general hospitals: These general hospitals cannot maintain quality staffs because they lack specialists. High quality care could be given in a unified system; many Veterans' Administration and some Public Health Service hospitals, which would be transferred to such a system, are already well staffed with specialists because of their association with teaching medical centers. We have found no other way to give high quality care to the armed forces.

2. As to the transfer of Veterans' Administration hospitals to the new Administration: If they were to remain separate, the new United Medical Administration would be a central health agency in name only. Only by incorporating the Veterans' Administration hospitals can an integration be achieved which will provide equally high-grade specialist care for the armed forces and the veterans. Only by this means can scarce medical manpower be efficiently utilized.

Congressional Policies

For this plan to function, it must be accompanied by a clear definition by the Congress of the rights and priorities to medical care of all the various classes of beneficiaries. Based upon such a new definition, this plan presupposes that the resources in medical manpower and the facilities of community hospitals—where these are of satisfactory quality—will be utilized for care of Federal beneficiaries to the maximum extent possible.

The principle should be that hospital care for Federal beneficiaries be planned in relation to the hospital resources of the country as a whole, not merely through construction of Federal hospitals as a class apart.

It must be constantly borne in mind that assumption of Federal financial responsibility is an entirely distinct question from provision of such medical care directly in Federal hospitals.

Beneficiaries

The basic question as to what the Government owes to its veterans and the dependents of members of the armed forces is a policy matter which must be determined by the Congress. The decision as to what financial burden for medical care is to be assumed is separate and distinct from the question as to whether such care should be given in Federal hospitals. But such a decision is essential for sound planning.

A single policy for dependents of armed forces personnel should apply to all three services. The right to medical care for dependents is an inducement to remain in the armed services, and is a morale factor. The question is really one of pay of the armed forces, except overseas and in posts in this country remote from adequate community facilities and professional personnel. In such areas, care by military doctors is essential.

Recommendation No. 5

Congress should define the beneficiaries entitled to medical care from the Government and prescribe how this care should be given.

IV. Further Recommendations

Integration With Non-Federal Hospital System

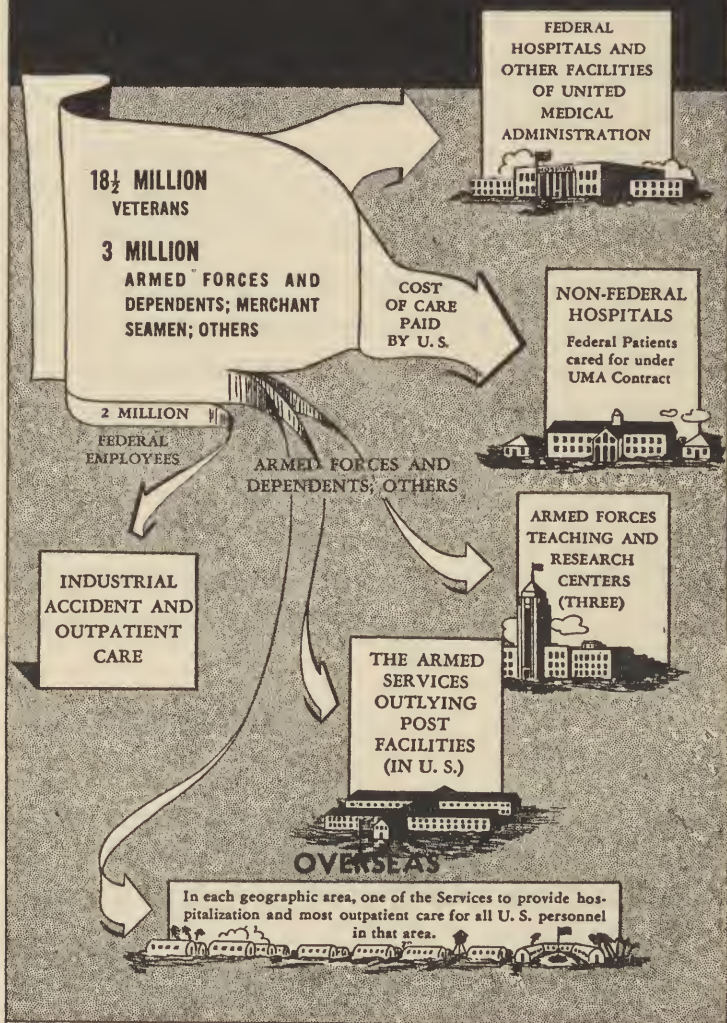
Inadequacies exist in the Nation's hospital plant. The Federal Government has recognized the need for aid in remedying them and is now giving such assistance. This effort would be furthered by hospitalizing Federal patients in non-Federal hospitals on a reimbursable basis wherever it is efficient to do so, instead of further enlarging the Federal hospital plant. In that way, many such patients could be cared for near home in their community hospitals. (See chart, Care of Federal Patients Under Proposed System.)

This step is further indicated because the Federal Government is dependent upon voluntary and other community teaching hospitals for undergraduate and postgraduate training of medical personnel, and for the advancement of medical science by joint efforts with the medical schools affiliated with them.

Recommendation No. 6

The present inconsistency in policy between the Federal hospital construction program and Federal aid to non-Federal hospitals under the Hill-Burton Act should be ended.

CARE OF FEDERAL PATIENTS UNDER PROPOSED SYSTEM



The Armed Services

It is basic that the armed forces must have supporting medical service subject to military control.

The proposal to transfer general hospitals and most station hospitals in the continental United States to a single national hospital system will eliminate much of the existing duplication and will conserve scarce professional manpower.

Overseas, the Secretary of Defense should assign to one of the services full responsibility for the hospitalization, and much of the out-patient care, of all United States personnel in each geographic area. This proved successful during the war; it should be done now in an even more systematic manner. This step would conserve scarce medical personnel and effect optimum use of facilities. The service having greatest responsibilities in an area would be the natural choice for the task there.

Recommendation No. 7

The control of medical policy in the armed services should be exercised by the Secretary of Defense.

National Defense

These recommendations, it is believed, are calculated to provide a sound organization, not only for our peacetime requirements, but also for war emergency needs. The United Medical Administration should give continuing attention to the wartime medical needs of the country, including the

status and availability of medical personnel and the relative facilities of Government and civilian hospitals. The overwhelming shortage of doctors which war would create could thereby be met by optimum utilization of those we have. Not only would the proposed single Federal hospital system reduce the need for full-time Federal doctors by making more care of Federal beneficiaries possible without withdrawing physicians from their communities, but it would also assist in saving doctors because it could be fully integrated with non-Federal hospitals. The problems of another war would mean that not as many physicians as in the last war could be taken from their communities. To do so would destroy essential civil defense.

Recommendation No. 8

The United Medical Administration should give constant attention to necessary measures for national defense.

Personnel Policies in Medical Services

The United Medical Administration should have full responsibility for recruiting, selecting, assigning, training, and otherwise handling its own professional and technical civilian personnel on the basis of standards determined by it but approved and enforced by the Civil Service Commission. It should make greater use of ancillary technical personnel.

Recommendation No. 9

Medical and other technical personnel in the Administration should be on a career service basis.

Aid to Medical Education

Many schools are in serious condition. Adequate facts on which to base the extent of, or to determine intelligently, the aid required are not now available. There should be a short-range survey immediately made by an independent commission appointed by the President to determine the real needs for emergency aid, amplified later by a longer range study. Any aid must be given in a manner to maintain the professional independence and the initiative of the schools, and in a way which will increase the output and result, partially at least, in meeting especially acute current deficiencies.

Recommendation No. 10

A survey should be made to determine the needs for emergency aid to medical schools.

Control of Disease

The necessity for medical care, which requires heavy expenditures and much personnel, must not be permitted to result in minimizing the even greater importance of controlling disease. Research must be stimulated, and supported to the

extent which may prove necessary, to the maximum potential of the skilled manpower available to conduct it.

Since the Federal Government now gives varying degrees of medical care to one-sixth of the Nation and since it may very well face expansion in veterans' hospitalization as veterans grow older and as their numbers increase, the Government can protect its financial position best by using every means to prevent disease rather than to treat it by unlimited hospitalization. This will also promote both the national welfare in peace and a stronger manpower to preserve our security in war. The highest priority in Federal medical expenditures should, therefore, go to the research and public health fields. We must, and to a large degree we can, if we will, control disease.

Recommendation No. 11

The highest priority in importance should be given to research, preventive medicine, public health, and education.

SEPARATE VIEWS OF COMMISSIONERS

Dissent by Chairman Hoover and Commissioner Manasco

Dissent by Commissioner Brown, with Concurrence by
Commissioner McClellan

Separate Statement by Vice Chairman Acheson, Com-
missioners Aiken and Rowe.

Dissent by Chairman Hoover and Commissioner Manasco

We wish to dissent vigorously from the action of the majority of the Commission in providing that the Board of United Medical Administration should be "advisory" only. Generally speaking, a board should not have administrative powers nor do we advocate that this Board have such powers. However, because the recommended consolidation of hospital and certain other medical services is such a revolutionary change from anything heretofore attempted in our Government we, in dissenting, have attempted to find an intermediate step that would overcome an admittedly critical situation and at the same time provide an orderly transition from an outmoded system to an efficient organization.

We are mindful of the validity of some of the arguments presented by members of the medical services of the armed forces. These representatives contend that to follow completely the recommendations of our task force would make it difficult for the armed forces to attract and hold specialists because of the inability of the services to offer opportunities to these specialists to follow their chosen careers. They also contend that it would not be possible adequately to train and retain disciplinary control over medical corpsmen and attendants. We agree in part with their contention. In order to overcome these valid objections, we believe that it is im-

perative that a board composed of the Surgeons General of the Army and Navy, the Air Surgeon, the Chief Medical Director of the Veterans' Administration, and the Surgeon General of the Public Health Service be established with power to determine the policies of the United Medical Administration.

The recommendation of the Commission, in effect, means a unification of hospital facilities serving several major departments and the Board proposed by us amounts to an interdepartmental committee to determine policy—this is a long-established practice in our Government. The top officials in the interested departments must have a real voice in determining the policies and objectives of the new organization. This does not mean vesting administrative authority in an independent board. It does mean that the responsible authorities of the departments affected would have a voice in the assignment of medical personnel and in the training of corpsmen and attendants of the medical services of the armed forces. This we feel must be done if the armed forces are to meet their obligations in time of peace and have available a trained nucleus of personnel capable of rapid expansion in event of war. It would also be possible under this proposal for personnel to be trained in hospital administration which is so important in time of peace and especially in time of war.

We sincerely believe that unless the Board is given such powers as recommended by us, the program will weaken if not destroy military medicine.

It has been suggested that the new organization should be placed in a department of welfare. Under ordinary circumstances we would agree with this proposition, but since we think that it is imperative that the Board proposed by us should have policy-making power, we do not think that a Cabinet officer should be placed in the embarrassing position of having an agency under him without the control of policy.

HERBERT HOOVER,
Chairman.

CARTER MANASCO,
Commissioner.

Dissent by Commissioner Brown

While Mr. Brown agrees with the desirable objectives of the report on Federal Medical Activities, he dissents from one of its principal recommendations, namely, that practically all of the hospitals of the armed forces be transferred to, and placed under the jurisdiction of, the proposed United Medical Administration.

It is the position of Mr. Brown that not only proper medical and hospital services are necessary at all times for the members of the armed forces but that also there must be maintained well-trained and highly skilled military medical and hospital personnel, composed not only of doctors but also of nurses and enlisted corpsmen who can train and direct others in time of war or other national emergency. It is just as necessary to have well-trained and highly skilled medical and hospital corps in the armed forces as it is to have aviation experts, battleship and submarine crews, and other military personnel especially qualified in the arts of war.

Instead of transferring all but a very few military and naval doctors and hospitals to a civilian agency under the control of a medical bureaucracy, Mr. Brown has suggested that the available beds and services in the hospital system of the armed forces be made available for the use of other Government beneficiaries, under proper supervision and restrictions which will protect their full interests.

The Commission's report unfairly charges that a critical lack of medical specialists exists in the armed forces. Mr. Brown contends that there is no shortage of military medical specialists. However, a shortage does exist in every other medical activity in both the Federal Government and civilian life. In regard to the availability of specialists in the armed services, Mr. Brown points out that, while no recent check has been made, prior to World War II 25 percent of all Army and Navy medical officers were recognized as specialists by, and were members of, the Nation's leading scientific and medical societies. Actually, the proportionate number of medical specialists in the armed forces was then more than double that in civilian life. In addition to the qualified specialists now in the armed services, over 1,000 highly skilled civilian medical and surgical specialists act as part-time consultants in connection with the care of military patients and in the training of additional medical personnel. Contrary to the Commission's report, the quality of medical care furnished to American military personnel is exceptionally high. It not only compares favorably with, but is believed to actually excel, the quality of medical care available to the civilian population of the United States.

For some time the medical services of the Armed Forces have been cooperating in the development of a program of unification of the medical facilities within the National Military Establishment. The medical manpower available to the armed services at the present time is still proportionately

higher than that available to the civilian population. The cost of medical services rendered each patient in the hospitals of the armed forces, is actually lower than in civilian life, despite the inclusion of the cost of maintaining stand-by military facilities.

Mention has been made in the Commission's report of the difficulty in obtaining trained medical personnel for the use of the armed forces. While there is a serious shortage of medical manpower throughout the entire Nation, the armed forces are actually accepting for service only those doctors and surgeons who graduate in the top fifth of their civilian medical school classes.

It is the contention of Commissioner Brown that those who fight the Nation's wars are entitled to the best possible medical and hospital care, not only from officer surgeons and doctors, but from the stretcher bearers and other trained enlisted men who give pain-relieving hypodermics and blood transfusions on the battlefield, and from the faithful nurses who serve in military hospitals on the land, at sea, and in the air.

So long as world conditions require the maintenance of strong armed forces to defend this Nation and the principles for which it stands, it is Mr. Brown's belief that the Congress of the United States should not permit any change to be made which will endanger either the quality or the quantity of the medical and hospital services our wounded may require. Certainly it would be ill-advised and foolish to injure or destroy those medical services of the armed forces which made

such an outstanding record of saving precious American lives in World War II in order to effect economies and efficiencies which can be just as easily obtained through other methods and by another type of organization, as has been outlined.

CLARENCE J. BROWN,
Commissioner.

Concurrence: I join in the general views expressed by Commissioner Brown.

JOHN L. McCLELLAN,
Commissioner.

Separate Statement by Vice Chairman Acheson, Commissioners Aiken and Rowe

We do not agree with the proposal of the majority to set up another new agency. It is unsound organization and unnecessary governmental structure.

We agree entirely with the recommendation to consolidate the major hospital activities of the Government. These functions would, if unified, be much more efficiently and economically performed. The economies would be huge. More important, the veterans and present personnel of the armed forces would receive much better care as the product of such consolidation.

But this proposal to place these hospital activities in a separate agency, and to take out of the present Federal Security Agency the Public Health Service and put it in that separate agency is not the way to achieve what both the majority and we agree is a desirable end. Such a combination serves only to splinter the Government's welfare functions. It would cause more of the organizational confusion which this Commission was created to terminate.

As we point out elsewhere in another report,¹ it is our view that the present Federal Security Agency should be renamed

¹ Report on Social Security; Education; Indian Affairs.

the Department of Welfare which would contain—as the Federal Security Agency does now—the health, education, and security functions of the Government. This is desirable to promote efficiency and economy, for one thing. For another, it is in accord with the basic principles of the general management of the executive branch, as outlined in our first report.

In our opinion the proposal to create an independent agency for these hospital activities violates two of those basic principles which were approved by the full Commission in that report. They are:

1. Government agencies should be grouped into departments according to major purpose.²
2. Government agencies should be consolidated into about one-third of the present number.³

Those principles are sound. The number of agencies reporting to the President must be reduced to a minimum. As a practical matter, the burden of coordination and direction at the Presidential level is already excessive.

In the face of this situation, the creation of another independent agency can only be justified by most extraordinary circumstances. We can find no such compelling reasons here. Nor have the majority stated such reasons. In fact,

² Recommendation No. 12, General Management of the Executive Branch, p. 34.

³ Recommendation No. 17, General Management of the Executive Branch, p. 36.

the opposite is true. There are direct administrative relationships between these hospital functions and the health, education, and security functions which require their over-all direction by a single official on behalf of the President.

A further reason for consolidating hospital activities with the health, education, and security functions is to prevent overemphasis on professionalism in these three fields. They should all be directed together by an administrator who is a generalist, responsive to the President. If they are separated the tendency to place a specialist in charge of each segment would be irresistible. This always results in advocacy, in the overemphasis of the specific interest and the role of professionals—whether doctors, educators, or social workers—to the detriment of the general interest.

Accordingly, we recommend:

The existing hospital activities of the Government should be consolidated. They should be placed in a new Department of Welfare and integrated with the health, education, and security functions of the Government which would also be placed in that Department.

But if the Congress does not accept this view . . .

We recommend in the alternative that, at all events, the Public Health Service be placed in the Department of Welfare even though the Government's hospital activities are consolidated in a separate agency.

We make this alternative recommendation for these reasons:

The hospital activities should, of course, be closely integrated with the other health functions of the Government. The health functions logically interlock with the education and security activities and should be grouped into one major purpose department whose over-all function is welfare. But if the Congress determines that hospital activities should be separated, it is our opinion that the other health activities of the Government bear a closer relationship to, and are so inextricably connected with, education and security functions that the Public Health Service should remain with them in one department and not be torn out to be placed in a hospital agency. The disadvantages flowing from a separation of Federal programs in the health, education, and security fields would far outweigh any advantages to be gained from consolidating hospitals with general health functions in an independent agency.

At the Federal level, general health functions—apart from the direct operation of hospitals—and education and welfare functions are primarily research, promotion, and the administration of grants-in-aid. Direct operations are in the hands of State, local, and private organizations. It is, then, essential that grants-in-aid be coordinated at the Federal level to insure an over-all consistency and balance and to simplify Federal-State relations. This can best be performed by strengthening the existing arrangements, not by pulling these functions apart and creating separate agencies.

On the functional side, the Federal administration of research, promotion and grants-in-aid for health, education, and security also require coordination. They are closely inter-related. Any Federal program to relieve shortages in professional health personnel, for example, must be developed with full awareness of the part to be played by educational institutions, and of the impact of that program upon our educational system. And this is also true in medical research which for the most part must be carried on by institutions of higher education. Community education on how to avoid illness and prevent diseases is an essential factor in the effectiveness of preventive public health work. Vocational rehabilitation which successively involves the physical restoration, vocational training, and economic security of handicapped individuals, affords another illustration of the three-way relationship among health, education, and security.

The social insurances are closely related to the whole series of health, education, and welfare services which a department of welfare should administer. These are complemented by public assistance which provides a life net below the social insurances. They are inextricably associated with health and with vocational rehabilitation. They help maintain the health, welfare, and education of children by safeguarding the family income. A major purpose of social insurance, as of health and education services, is to enable the individual to provide for his own security and that of his family.

Instances of the interrelationships among health, education, and security can be multiplied many times over. These functions all tie together. Hospital activities should be integrated with them. But if they are not, the other health functions should remain where they are.

DEAN ACHESON,
Vice Chairman.

GEORGE D. AIKEN,

JAMES H. ROWE, Jr.,
Commissioners.

Additional Statement of Commissioner Pollock

While I concur with the recommendations of the Commission report, there are a number of issues raised in the dissents of several Commissioners on which I should like to make my position clear.

First. A consolidation of the major medical services of the Federal Government is essential not only to achieve huge economies but, through better utilization of scarce medical and technical manpower, to improve greatly the quality of the medical services rendered both by the military and civilian agencies. Speaking on this point our task force says:

. . . This radical departure from traditional functions is proposed, not merely to save money, but because it is the only means by which high quality care can be maintained with the present shortage of doctors in Federal service. Furthermore, it would provide better medical protection in time of war.

Second. The consolidation does not imply that medical services essential to the Armed Forces would be transferred to the United Medical Administration. Both our medical task force and the Commission recognize that the Armed Services require certain essential medical services which it is not our intention to disrupt. This intention is reaffirmed in the following statement of our task force's subcommittee on Armed Forces Hospitalization:

. . . In exploring the possibilities for more efficient use of the medical potentialities of the nation, this committee early arrived at the firm conclusion that so much of a medical service as is in direct support of an armed force is, and must continue to be, inseparable from that force. The functions of the medical service are diverse, and the responsibilities of commanders too inclusive, for medical personnel to be allocated and withdrawn solely on the basis of current need for medical care.

There is at present, however, a function of medical service that is not one of direct support of an armed force. This is purely professional care in hospitals of serious cases requiring expert medical or surgical skill. A high proportion of such cases are forever unfit for further military service; and such as do recover are of little military value during the period of their hospitalization. Such patients are primarily a medical rather than a military responsibility and . . . there is no impelling reason for treating them in military hospitals.

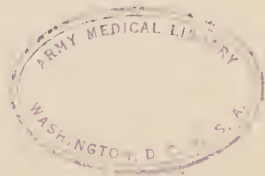
Third. The creation of a United Medical Administration does not imply any violation of fundamental principles or organization. Bringing together all the major medical functions of the Federal Government under the administration of one agency provides us with one of the clearest examples of organization by major purpose that it has been possible for our Commission to propose. The argument that it would leave outside of the administration such related functions as the Children's Bureau, the Office of Vocational Rehabilitation, and the Office of Education, in my opinion, has little or no bearing upon the problem of consolidating the major direct medical services of the Government. No less than 46 Federal agencies are engaged in some kind of medical service. While total expenditures of the Federal Government for medical services amounted to \$1.2 billion in fiscal year 1948,

less than two percent of this was allocated to the Children's Bureau. The Bureau in turn does not use the money for direct medical services but allocates it to the States in the form of grants-in-aid to support local crippled children, and maternal and child health programs. Furthermore, in our report on Social Security and Education, we have recommended against integrating the grant-in-aid programs of the Children's Bureau with those of the Public Health Service until the promotional phases of the former have ended and a more integrated approach has developed to the whole problem of Federal grants-in-aid.

Similarly the Office of Vocational Rehabilitation does not engage in direct medical services but allocates money to the States in support of approved programs for vocational rehabilitation. In the fiscal year 1948 appropriation for grants to the States for all vocational rehabilitation activities amounted to \$18 million, of which only \$2.2 million was spent (and this, locally) for medical examinations, treatments, hospitalization, and prosthetic appliances.

As far as the Office of Education is concerned, our task force reports that all of its activities relating to health are so small and so incidental to the other work of the agency that it is impractical to try to allocate any specific percentage of the budget or staff to health.

Fourth. Although I am in favor of the ultimate consolidation of the United Medical Administration within an executive department which will also include the major social



security and education functions, I nevertheless believe that, at the present time, practical considerations indicate it would be better to forego this as an immediate step in order to achieve our most important goal—unification of the major medical services.

My reasons for recommending a separate United Medical Administration at this time are as follows:

a. The task of bringing about this consolidation is such a gigantic problem that, initially at least, the agency deserves a much higher position in the hierarchy of the Government and the best top managerial and professional talent that can be obtained. Both of these needs are more easily supplied if a separate agency is created.

b. The agencies principally interested in the reorganization—the Veterans' Administration and the Military Establishment—could be expected to voice less vigorous opposition than if the medical services were to be associated with education and social security functions.

c. The transfer of the major medical functions to a separate administration, as a first step in reorganization, does not preclude an ultimate consolidation of the United Medical Administration with the education and social security functions at some later date after the tremendous task of consolidation has been completed and the new administration has become a smoothly operating and stable agency.

This recommendation is in keeping both with my belief that the number of agencies reporting to the President should be kept at a minimum, and with the concept that organization is a dynamic process and therefore whatever we propose here as an initial step in reorganization need not necessarily determine the ultimate character of the organization when quite different circumstances obtain.

Fifth. I am unalterably opposed to the suggestion that the new United Medical Administration be made responsible to a Board which would dictate its policies. Time and again such boards have proved to be unable to keep away from log-rolling tactics or from delving into administrative matters. Moreover, the Board, as suggested (p. 34), would comprise three members of the Military Establishment—the Surgeons General of the Army and Navy and the Air Surgeon, one representative of the Veterans' Administration, and the Surgeon General of the Public Health Service. Under such an arrangement the Military Establishment could invariably muster a majority to determine policies affecting not only all of the hospitals in the consolidated service but all of the present functions of the Public Health Service including preventive medicine and research, as well as those of the Food and Drug Administration.

I am, therefore, convinced that the management of the new agency should be placed under an administrator as recommended in the Commission report. He should be assisted by a part-time advisory board on which the Veterans' Ad-

ministration and the Military Establishment would have representation. Under this type of organization responsibility would not only be fixed but the legitimate needs of the related services would be made known to the administrator. To assign the management of this enterprise to a board representing the present interested agencies is to run the risk of not achieving consolidation at all.

JAMES K. POLLOCK,
Commissioner.

Related Task Force Report

Submitted separately to the Congress in printed form, as Appendix O, are the task force report on Medical Services and its supplement. Additional papers are transmitted in type-script.

Acknowledgment

The Commission wishes to express its appreciation to the following persons for their preparation of the task force reports:

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REAR ADMIRAL JOEL T. BOONE (MC), USN, executive secretary, Committee on Medical and Hospital Services in the Armed Forces.

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A. R. DOCHEZ, M. D., College of Physicians and Surgeons, Columbia University, New York, N. Y.

On Tuberculosis

ESMOND R. LONG, M. D., director, Henry Phipps Institute, University of Pennsylvania, Philadelphia, Pa.

ROBERT PLUNKETT, M. D., New York State Department of Health, Albany, N. Y.

On Hospitalization

BASIL MCLEAN, M. D., director, Strong Memorial Hospital, Rochester, N. Y.

MAXWELL E. LAPHAM, M. D., dean, school of medicine, Tulane University, New Orleans, La.

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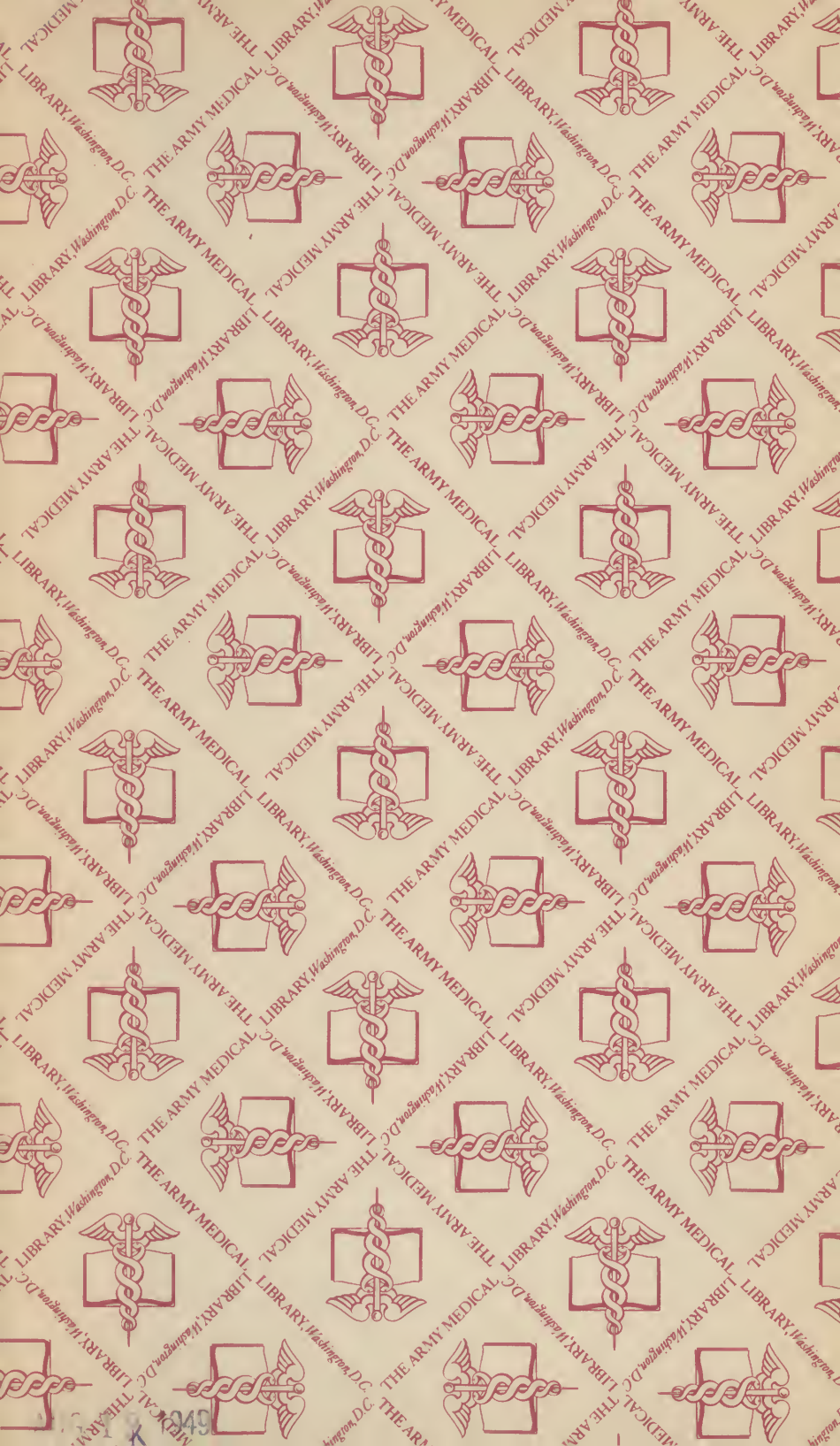
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